Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JTJ Marketing, Inc

Respondent Name
TPCIGA for Lumbermens Mutual

MFDR Tracking Number
M4-13-2419-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
May 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim for CPT 97799-CP-CA was paid on 02/19/2013 for $106.25. In reviewing payment and documentation we discovered claim was originally keyed in with wrong with incorrect units. Reconsideration was processed on 03/18/2013 to Bunch & Associates for request of additional payment along with documentation on additional units. "

Amount in Dispute: $743.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2012	97799-CP-CA	$743.75	$743.75

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets medical fee guidelines for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 309 – Description not Available
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider. We are recommending further payment to be made for the above noted procedure code.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?

2. What is the recommended payment amount for the services in dispute??

Findings

1. Per 28 Texas Administrative Code §134.204(h)(1)(A) states in pertinent part, "If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed… The hourly reimbursement rate for a CARF accredited program shall be 100 percent of the MAR. 28 Texas Administrative Code §134.204(h)(5)(B) states, "Reimbursement shall be $125 per hour…"

   Review of the submitted documentation finds the following;

Date of Service	Submitted Code	Units	Billed Amount	Maximum Allowable Reimbursement	Paid Amount	Amount Due
December 14, 2012	97799 CP CA	8	$1666.80	$125 x 8 units = $1,000	$106.25	$893.75

2. The total recommended payment for the services in dispute is $1000.00. This amount less the amount previously paid by the insurance carrier of $106.25 leaves an amount of $893.75. The requestor is seeking $743.75. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $743.75.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $743.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	June 4, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.